MEETING SUMMARY
RURAL & FRONTIER HEALTHCARE SOLUTIONS WORKGROUP MEETING

Thursday, March 12, 2020 | 9:00 a.m. – 4:00 p.m. MST
JRW Building, 700 W. State St., Boise

Participants

Members: Abner King, Brad Turpen, Christina Thomas, Darin Dransfield, Hillary Klarc, Jake Erickson, Janet Reis, Keith Gnagey, Larry Tisdale, Lenne Bonner (phone), Linda Rowe, Michael Blauer, Patt Richesin, Paul Smart

Staff: Stephanie Sayegh, Mary Sheridan, Matt Walker

Guests: Dr. Craig Jones, Sara Adornato, Tyler Freeman

Facilitators: Elizabeth Spaulding, Anna Wiley

Welcome & Introductions

Elizabeth Spaulding, facilitator, began the meeting with an overview of meeting goals and the agenda. Keith Gnagey moved to approve the meeting minutes; Patt Richesin seconded the motion. The motion was approved.

Update on Action Items

Mary Sheridan, Department of Health and Welfare (DHW), introduced the Rural & Frontier Health Solutions Workgroup draft one-page informational flyer. This document may be used to inform board members, hospital leaders, and other stakeholders on the vision and process for participating in value-based system changes. The workgroup collectively read and reviewed the information and offered edits, specifically including additional explanatory statements to expand background information and offer examples of what other states have done. Mary will update the one-pager, review the document internally within DHW and add graphics to be reviewed at the next meeting.

Mary also provided the workgroup an update on the data requests submitted to Medicaid, which are still pending. Lenne Bonner will submit a request for similar data to her contact at Blue Cross. It was determined that all data requests should be consistent in order to make accurate comparisons.

Stephanie Sayegh, DHW, provided an overview of her research on additional value-based assessment tools that could be offered to hospitals. She concluded that the Value-Based Care Assessment Tool is still

the best option to move forward. Participants discussed who should disseminate the tool, which hospitals should complete the assessment, and how to frame the benefits from the assessment. Larry Tisdale, Idaho Hospital Association, will write a "why" statement and Mary Sheridan will send the assessment to hospitals on behalf of the workgroup. Abner King, Syringa Hospital & Clinics, will share the results of his hospital's assessment with the workgroup.

Mary provided a brief update on the CMMI grant opportunity. The federal funding opportunity is still pending clearance. Dr. Craig Jones mentioned that the process can take time, but to stay tuned for further information.

At the previous work group meeting, participants requested to speak with a CEO from a hospital that has implemented a value based model in order to learn more about the decision-making process for engaging in the model. Larry Tisdale spoke with Bill Jolley, Tennessee Hospital Association, about their model. Larry's takeaways were as follows: the Tennessee financial model was not complicated, but would be difficult for small hospitals to implement. It provides predictable cash flows, but does not fix profit margins the way the Pennsylvania model does. The Tennessee model also does not fix the profitability issue that Idaho is aiming to address. Based on this information, participants discussed the type of "cost-shift model" that is currently envisioned.

Discussion with Sara F. Adornato, CEO, Barnes-Kasson County Hospital, Susquehanna, Pennsylvania

Sara Adornato, Barnes-Kasson County Hospital, joined the workgroup via remote video to discuss her hospital's participation in the Pennsylvania model and answer questions from the workgroup. Sara has been the CEO of her hospital for ten years and is in the second year of the global budget pilot program. The hospital serves a high percentage of Medicare and Medicaid patients, and ultimately their incentive to participate was financial stability. Significant discussions needed to occur with her Board for them to feel confident in participating in the program. Sara's key takeaways were to remain open-minded through the discussions with Board members and to be prepared to have difficult discussions with both payers and providers. She also mentioned that the community has been encouraged by the prospect of change and that most providers have been supportive.

Workgroup Questions:

- *Do you anticipate changing any scope of service?* Currently no. We have a transformation plan, but there is no change in scope of service.
- *In planning this, what was it in the budget structure that allowed you to transform? How did you structure the budget?* The Pennsylvania budget looked at current year payer revenue or a 3-year lookback and based the budget on whichever was higher. We still receive Medicare and Medicaid costs and are still filing cost reports. The Pennsylvania model did not add anything in for innovation or infrastructure. If we are doing all these things to improve quality, they anticipate that as they reduce high utilization, that cost savings will be retained by the hospital.
- *Can you outline key elements of the transformation plan? What were the biggest drivers?* Each hospital sat down with the state to work through what was best for each hospital. We have a small team with very few assets. We were dedicated to one project each year. We focused on COPD in year-one. We needed to work with other providers to create best practices and outpatient services to keep patients out of the hospital. Needed to bolster outpatient pulmonary rehab. Case management and care management were also important. The focus for

year-two is opioid addiction and outpatient care. The focus for year-three is geriatric behavioral health.

- *Has the state provided guidance and feedback?* State has been a great working partner with the hospital. The state understands a lot of the issues we are working through, supports the sharing of data and assists in setting up calls with other hospitals.
- *Is there anything in the plan regarding partnerships with large primary care or ambulatory centers?* There are primary care links within system. This makes it easy because everything is self-contained.
- *How stable is the hospital financially after adopting the model?* First year had a better financial year than in the past. Reliable budget helped forecast expenses. Ability to invest in infrastructure hasn't been seen. Stable budget has allowed us to feel more comfortable taking other risks.
- *Do you also employ specialists in your hospital?* Most physicians are primary care, a couple specialists in cardiology/dermatology come in.
- *Did you have to repurpose or retrain staff?* There were no real impacts in the clinic. The only aspect of the hospital that is operating under the model is inpatient/outpatient. We have looked at some areas in our inpatient care, we staff for 18 and repurpose nurses if census is lower. Some nurses have repurposed their hours into the clinic.
- *How you are looking at this as a sustainable financial model? What would be the thing that could influence the + or - in your financial model*? Revenue doesn't fluctuate. Having that predictability has been helpful for planning and management services. Short term stops the bleeding.
- *Has the model given you a better grasp on risk?* It's given us insight into care gaps. The model has increased the data we have received. It has allowed us to understand where we can improve social determinants of health.
- *Tell us more about the feedback you have received from commercial payers.* It's been a positive experience. We have quarterly providers and payer meetings. At the beginning there were misunderstandings. There is still some tension between payers ensuring there is good quality healthcare, and the scaling up of payments to rural hospitals.
- *Tell us about the technical assistance you received.* Care management consultant paid for by the state to teach about best practices. Assessments of COPD care with nurses and providers. This has been free of charge to the hospitals.

Model Development and Discussion

Keith Gnagey, Teton Valley Health Care, presented the initial draft budget model that the Budget Model subcommittee developed based on considerations and feedback identified at the previous work group meeting. This draft addresses the scope of the model, the global budget variables, the Critically Integrated Network (CIN) variables, and remaining issues that have been identified and need to be addressed. Keith reviewed each section, providing explanations on the assumptions built into each section and identifying gaps or changes that the subcommittee felt still needed to be discussed.

Initial feedback on the model was very positive. Work group members recommended adding sections to the model that address data and analytics, governance, and leadership and education. Significant discussion occurred, however, on the foundational question of the ultimate vision or desired outcome of this model. Is the vision to stabilize the finances of critical access hospitals, ensure sustainable access to

care in rural communities, or transform healthcare delivery to a more value-based model? How broad is this scope with regard to local, regional or statewide efforts?

Other significant discussion points included how to account for patient behavior; how to engage with larger medical systems; how to identify and manage risk; how to access and utilize data to drive decisions; payer alignment considerations; and quantification and redistribution of cost savings.

In order to help develop a visualization for the model that addresses some of these key questions, Dr. Craig Jones agreed to provide a rubric of models from other states, as well as a diagram that explains how cost savings are shared and redistributed under a global budget model. Tyler Freeman with Kootenai Healthcare will also work with the subcommittee to develop a logic model.

Medicare Data

The workgroup discussed data needs and shared the data that has been collected to date. Linda Rowe, Comagine Health, reviewed the data collected on Medicaid recipients. The workgroup then discussed what types of data would be most beneficial for helping shape the Idaho model and allow for monitoring of progress. Patt Richesin invited one of her data analysts to the meeting (Tyler Freeman) who has agreed to help guide the workgroup towards data points that would be pertinent and valuable, as well as support analysis of data. A number of workgroup members agreed to reach out to their contacts/sources of data to request the same categories of data so that there can be a broader, consistent analysis of costs and populations.

Identify Action Items and Next Steps

Work group participants determined that an in-person meeting in April is preferred, but acknowledged that adjustments may need to be considered in light of the emerging covid-19 situation. DHW will support the Budget Model subcommittee, as well as monitor the ability to convene in Boise in April.

Action Items:

- Assessment Tool
    - Develop a “Why” statement for the Assessment Tool – Larry Tisdale
    - Share example of assessment results – Abner King
- Idaho Model
    - Develop vision statement
    - New sections: Data, governance, and education
    - Logic model – Dr. Craig Jones
- Data Collection
    - The following data will be collected:
        - National level operating margins data – Larry Tisdale
        - Blue Cross data – Lenne Bonner
        - Data from payers – Hilary Klarc